MACRA/MIPS AND PATIENT CENTERED MEDICAL HOMES

CRITICAL ACCESS HOSPITAL ADMINISTRATOR'S MEETING

Lance W. Keilers, MBA, CAPPM

September 13, 2016

Learning Objectives

- Recognize current changes in rural hospital delivery systems
- Identify new models of care (Patient Centered Medical Homes) in rural healthcare
- Discover ways to positively impact rural healthcare quality and engage the community

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Special Thanks!

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Healthcare Today

- High Deductible Health Plans
  - Underinsurance
- State Budget Deficits
- Recovery Audit Contractors (RAC)
- Reduced Re-admissions
- Accelerating shift to outpatient care
- *MACRA (SGR Fix)*
- Comprehensive Pay Model
- 340B attacks
- New payment models
- Bipartisan Budget Act of 2015

SGR Fix (MACRA) – Rate Changes Summary

Time frame	Rate Increase
2016 – 2019	0.5%
2020 – 2025	0%. Adjustments made based on physician's choice to participate in 2 track program of MIPS or APM program • APM 5% bonus (2020 – 2024; fee increase of 0.75%/yr.) • MIPS -4 to +9%
2026+	• 0.75% for physicians participating in MIPS (Merit-Based Incentive Payment System) or an APM (Alternative Payment Model) program • 0.25% for all other physicians

•Sources: Health Affairs, Modern Healthcare, Congressional Budget Office

MACRA - MIPS

- April 16, 2015 – MACRA became law and SGR is out
- Merit-Based Incentive Payment Systems ("MIPS") and Alternative Payment Systems ("APMs")
  - Adjustments to FFS payments through MIPS based on:
    - Quality of Care (PQRS)
    - Resource Use (Value-based payment modifiers)
    - Meaningful Use EHR
    - Clinical Practice Improvement Activities
  - **Both Positive and Negative Adjustments**
    - Negative adjustments of 4% in 2019, 5% in 2020, 7% in 2021, and 9% in 2022
    - Positive adjustments of up to 3X the negative adjustments
- EXCEPTIONAL performers receive additional incentive payments up to 10% of their FFS Medicare payments per year

Healthcare Today

- Coverage Expansion
  - Currently, Medicaid covers only 45% of poor (≤ 100% FPL)
  - 16 million new Medicaid beneficiaries; mostly "traditional" patients
  - FMAP for newly eligible: 100% in 2014-16; 95% in 2017; 94% in 2018; 93% in 2019; 90% in 2020+
  - Establishment of State-based Health Insurance Exchanges
  - Subsidies for Health Insurance Coverage
  - Individual and Employer Mandate
- Provider Implications
  - Insurance coverage will be extended to 32 million additional Americans by 2019
    - Expansion of Medicaid is major vehicle for extending coverage
  - ***Traditionally underserved areas and populations will have increased provider competition***

Healthcare Today

Medicare and Medicaid Payment Policies

- Medicare Update Factor Reductions
  - Annual updates will be reduced to reflect projected gains in productivity
- Medicare and Medicaid Disproportionate Share Hospital (DSH) Payment Reductions
- Independent Payment Advisory Board (IPAB)
  - Charged with figuring out how to reduce Medicare spending to targets with goal of $13B savings between 2014 and 2020

Healthcare Today

- Medicare and Medicaid Delivery System Reforms
  - Expansion of Medicare and Medicaid Quality Reporting Programs
  - Medicare and Medicaid Healthcare-Acquired Conditions (HAC) Payment Policy
  - Medicare Readmission Payment Policy
    - Hospitals with above expected risk-adjusted readmission rates will get reduced Medicare payments
  - Value based purchasing
    - Medicare will reduce DRG payments to create a pool of funds to pay for the VBPP
    - 1% reduction in FFY 2013, Grows to 2% by FFY 2017
  - Bundled Payment Initiative
  - Accountable Care Organizations
    - Each ACO assigned at least 5,000 Medicare beneficiaries
    - Providers continue to receive usual fee-for-service payments
    - Compare expected and actual spend for specified time period
    - If meet specified quality performance standards AND reduce costs, ACO receives portion of savings

Population Health Strategies –

Develop Population Health building blocks

- Goal: Infrastructure to manage self insured lives and maximize FFS utilization and quality incentives

- Initiatives:
  - PCMH or like structure
  - Care management
    - Discharge planning across the continuum
      - Transportation, PCP, meds, home support, etc.
    - Transitions of care (checking in on treatment plan)
      - Medication reconciliation
      - Post discharge follow-up calls (instructions, teach back, medication check-in)
      - Identifying community resources
      - Maintain patient contact for 30 days
  - Develop claims analysis capabilities/infrastructure
  - Develop evidenced based protocols

Minnesota results show cost-cutting promise of patient-centered health care homes

By Debra Miller Tuesday, June 28, 2016 at 06:10 PM
Council of State Governments Knowledge Center

Minnesota was an early adopter of the use of health care homes, and a five-year study of their impact shows promising results for any state looking to reduce health costs and improve patient outcomes.

- "Given how much is spent for Medicaid, Medicare and dually eligible enrollees, you can create large savings and bend the cost curve," says Douglas Wholey, a professor of health policy at the University of Minnesota and the study's lead evaluator.
- The savings amounted to 4 percent to 4.5 percent per year over the five-year study period — **for a total of about $1 billion between 2010 and 2014 —** a rate that Wholey says is consistent with past studies of health care homes.

Why are we talking about PCMH today?

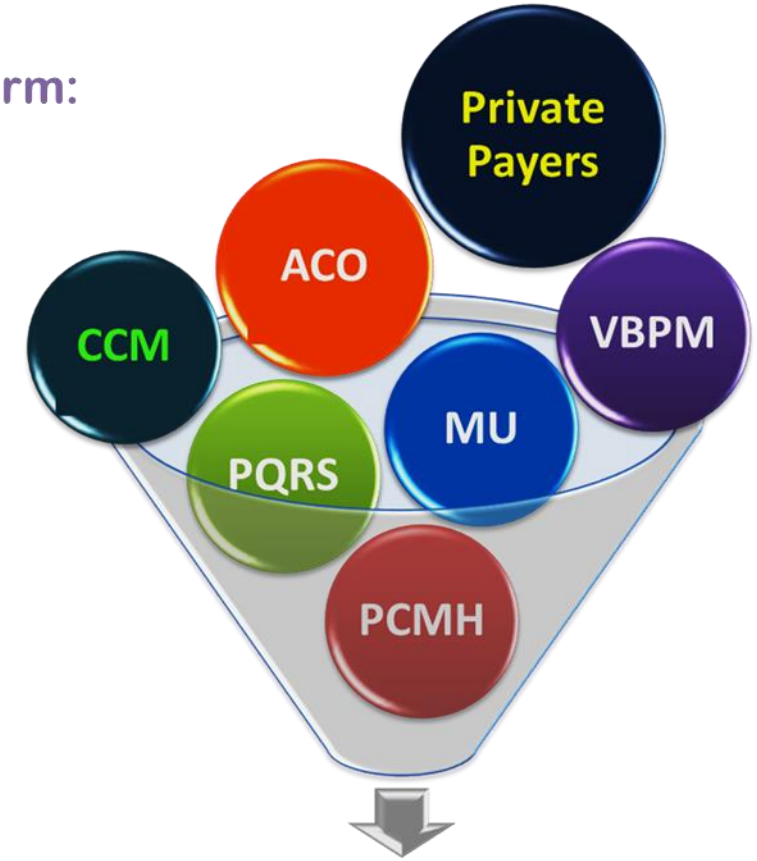
$3,000,000,000,000 spent on health care in U.S. every year

Triple aim of health care reform:

- **Better care**
- **Better health**
- **Lower cost**

CMS Initiatives

ACO – Accountable Care Organization
CCM – Chronic Care Management
MU – Meaningful Use
PCMH – Patient Centered Medical Home
PQRS – Physician Quality Reporting System
VBPM – Value Based Payment Modifier



One unified payment method

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PCMH is foundational to reform because Primary Care is foundational to health

The Patient Centered Medical Home

1967 - American Academy of Pediatrics (AAP)
A central location for archiving a child's medical record

2002 - American Academy of Pediatrics (AAP)
Care that is: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective

2007 – Joint Principles (AAFP, AAP, ACP, AOA)

1. ***Personal physician***
2. ***Physician directed medical practice***
3. ***Whole person orientation***
4. ***Care is coordinated and/or integrated***
5. ***Quality and safety***
6. ***Enhanced access***
7. ***Payment that recognizes the value added***

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National Committee for Quality Assurance (NCQA)

2008 - *PCMH Recognition Program - An operational framework for the medical home*

- Business operations

  Scheduling, Hours, Phones, Job Descriptions, Team-Care

- Technology

  EHR, Data, Meaningful Use, Health Information Exchange

- Care coordination

  Diagnostics, Specialists, Community Resources, Hospitals, ED

- Care management

  Preventive, Chronic, Care-Planning, Health Assessment

- Quality improvement

  Patient Experience, Clinical Quality, Methodology, Reporting

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The Essence of Medical Homes

- Access to care
- Proactive management (outreach)
- Identify at-risk and vulnerable patients
- Relentless, customized interventions
- Measure and improve continuously

Camden, NJ – Dr. Jeffrey Brenner

2008 - $460 million (90%) spent on 20% of patients.
#1 patient - $3.5 million

- ✓ Used data to locate "hot spotters" and "hot spots"
- ✓ High intensity hands-on in-person interventions
- ✓ Family physician, nurse practitioner, social worker

- ✓ 40% reduction in ED visits
- ✓ 56% reduction in overall spending

Source: Gawande, A. (2011, January 24). The Hot Spotters. The New Yorker

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Benefits of the Medical Home

To the Practice…

- More efficiency
- Better workflows
- More adherence
- Less burnout
- Happier staff
- Happier patients
- Better payments

To the Patient…

- Better health
- Better experience
- Coordination
- More resources
- Better access
- More support
- Lower costs

To the System…

- Reduced costs
- More preventive and proactive care
- Healthier and more productive communities

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Medical Home Support in Every State

CMS Comprehensive Primary Care Initiative	CMS Advanced Primary Care Practice Demonstration	HRSA Quality Improvement and PCMH Development
$1 Billion CMS Innovation Grants	CMS Shared Savings Program (ACOs)	State Medicaid Initiatives
Commercial Payers PCMH Initiatives	Large Employers Initiatives	VA and DoD Initiatives

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Medical Homes Outcomes in a Nutshell

Hospital Utilization
- Admissions
- Readmissions
- ED visits

Primary care Utilization
- Visits
- Screening
- Immunizations

Cost of Care
- Private payers
- Public payers
- Employers

Quality Process Measures
- Chronic care
- Preventive care
- Patient satisfaction

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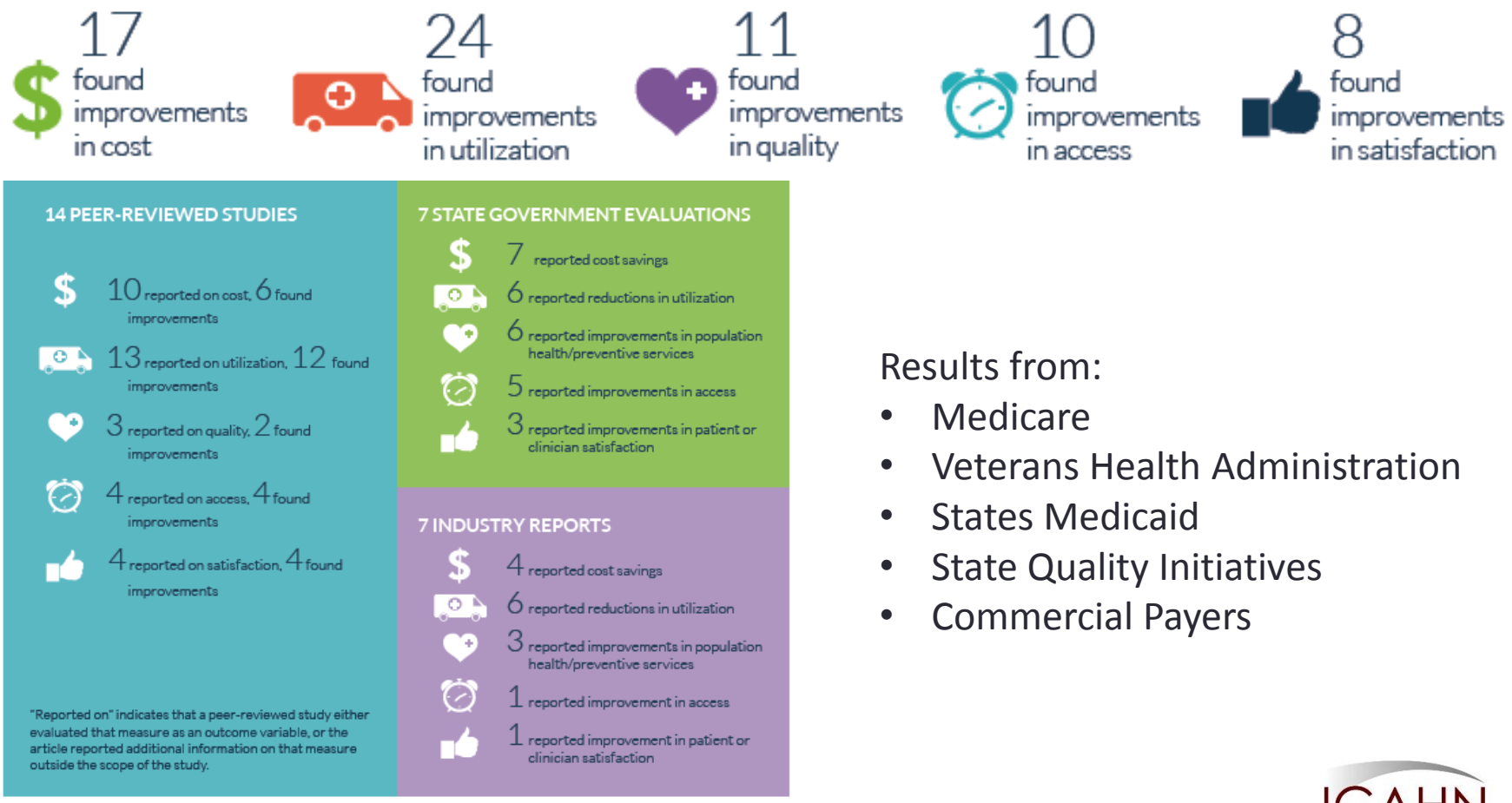
Overview of PCMH Evidence 2013-2014

Aggregated outcomes from the 28 peer-reviewed studies, state government program evaluations, and industry reports:



Results from:

- Medicare
- Veterans Health Administration
- States Medicaid
- State Quality Initiatives
- Commercial Payers

Source: Nielsen, M., Gibson, L., Buelt, L., Grundy, P., & Grumbach, K. (2015). The Patient-Centered Medical Home's Impact on Cost and Quality, Review of Evidence, 2013-2014.

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PCMH: The Foundation of Accountable Care

- Patient-Centered Medical Homes
  - Charged to provide individualized team-based care while providing population health management to reduce costs, improve outcomes and patient experience
- Accountable Care Organizations
  - Provider-based organizations charged to provide the governance and resources necessary to reduce costs, improve outcomes and patient experience for the patients attributed to their population

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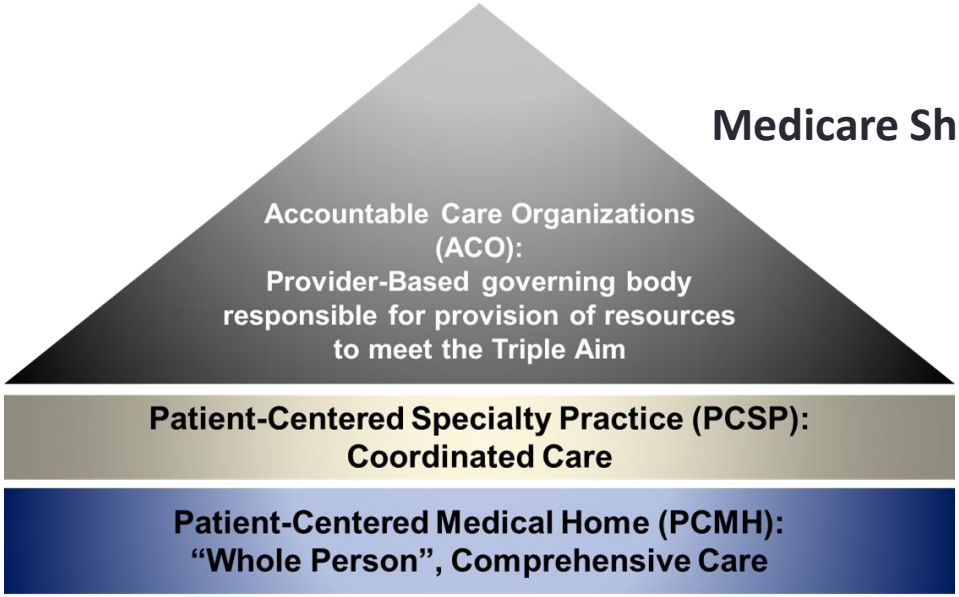
PCMH: The Foundation of Accountable Care



Medicare Shared Savings Program (MSSP) ACO

The ACO 33 Quality Measure Domains

- Patient Experience
- Care Coordination/Patient Safety
- Preventive Health
- At-Risk Patient Population

The PCMH model of care guides policies and processes, and provides the tools, to initiate and sustain changes in practice operations to enable improved performance on ACO measures, and accurate evaluation thereof.

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NCQA PCMH Standards

PMCH 1: Patient Centered Access

Appointments, same day, after hours, phone email advice…

PCMH 2: Team Based Care

Care team, continuity, language services, education...

PCMH 3: Population Health Management

Evidence based, data, health assessment, outreach…

PCMH 4: Care Management and Support

Identify patients, care planning, self-care support…

PCMH 5: Care Coordination and Care Transitions

Orders, referrals, transitions of care track and follow-up…

PMCH 6: Performance Measurement and Quality Improvement

Implement, measure, report on Quality Improvements

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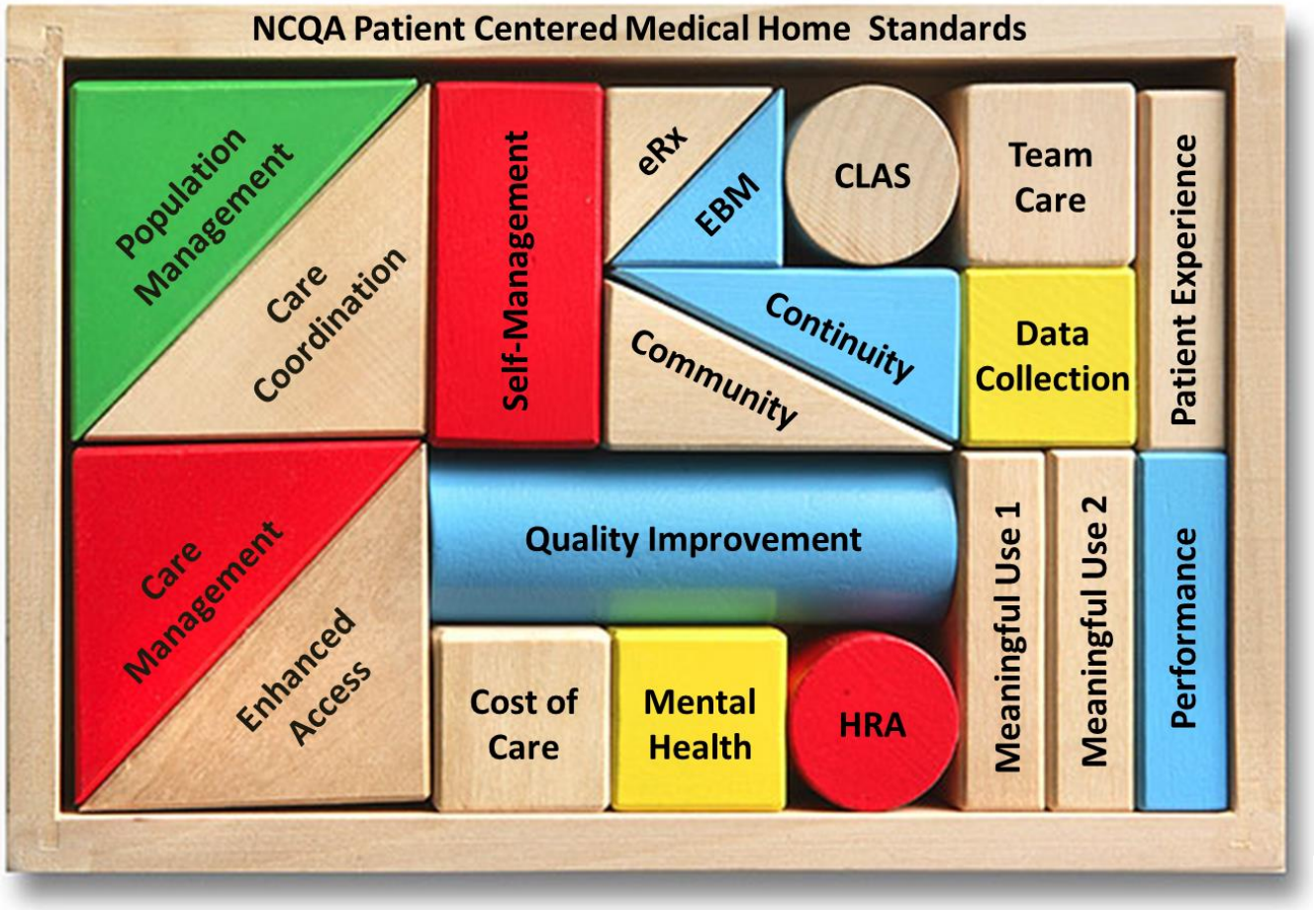
A National PCMH Framework

There is hardly anything that occurs (or should occur) in a high-performing primary care practice that is not addressed by the NCQA PCMH Standards



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NCQA PCMH Recognition

- ***What it is***
  - A journey, not an event
  - A guided process for change
  - A learning experience
  - Non prescriptive, personalized framework
  - Essential for ACO shared savings

- ***Advantages of formal recognition***
  - Nationally accepted "gold standard"
  - Increasingly used in "preferred" or "tiered" directories
  - **Increasingly used for value-based incentives**
    - **Public payers**
    - **Commercial payers**
    - **Employers**
    - **Enables complex care management billable services**
    - **Tied to pending SGR payment reform (5%)**
  - Marketing advantage

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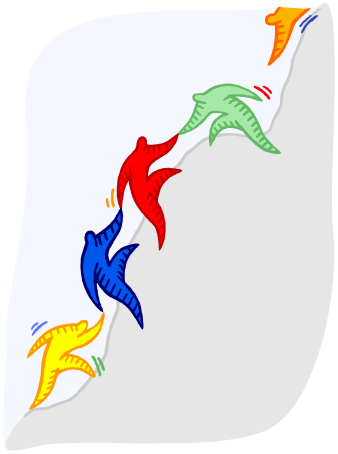
The PCMH Champion

PCMH is a team effort – everybody should participate but every practice needs champions:

- Willing and able to learn and teach the PCMH model
- Super-user of practice transformation vision and mission
- Create inspire and energize the team
- Push forward while leaving no one behind
- Empowered to take responsibility for the overall project
  - Timelines
  - Resources
  - Milestones
- Define, manage and inspire others to complete tasks
- Serve as a liaison to the ACO community



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NCQA PCMH 2014 Standards

Points	Standard/Element
10	**PMCH 1: Patient-Centered Access**
4.5	Element A Patient-Centered Appointment Access
3.5	Element B 24/7 Access to Clinical Advice
2	Element C Electronic Access
12	**PMCH 2: Team-Based Care**
3	Element A Continuity
2.5	Element B Medical Home Responsibilities
2.5	Element C Culturally and Linguistically Appropriate Services (CLAS)
4	Element D The Practice Team
20	**PCMH 3: Population Health Management**
3	Element A Patient Information
4	Element B Clinical Data
4	Element C Comprehensive Health Assessment
5	Element D Use Data for Population Management
4	Element E Implement Evidence-Based Decision Support

Points	Standard/Element
20	**PCMH 4: Care Management and Support**
4	Element A Identify Patients for Care Management
4	Element B Care Planning and Self-Care Support
4	Element C Medication Management
3	Element D Use Electronic Prescribing
5	Element E Support Self-Care and Shared Decision Making
18	**PCMH 5: Care Coordination and Care Transitions**
6	Element A Test Tracking and Follow-Up
6	Element B Referral Tracking and Follow-Up
6	Element C Coordinate Care Transitions
20	**PMCH 6: Performance Measurement and Quality Improvement**
3	Element A Measure Clinical Quality Performance
3	Element B Measure Resource Use and Care Coordination
4	Element C Measure Patient/Family Experience
4	Element D Implement Continuous Quality Improvement
3	Element E Demonstrate Continuous Quality Improvement
3	Element F Report Performance
0	Element G Use Certified EHR Technology

Recognition Levels	Required Points	Must-Pass Elements
Level 1	35–59 points	Elements marked in red font are MUST PASS
Level 2	60–84 points	6 of 6 elements are required for each level
Level 3	85–100 points	Score for each Must-Pass element must be ≥ 50%

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The Essential Elements of PCMH

PCMH 1A Patient-Centered Appointment Access

1. Same day appointments
2. After hours appointments
3. Alternative type encounters
4. Analyze schedules
5. Act to improve schedules

PCMH 2D The Practice Team

1. Formal organizational structure
2. Regular meetings (huddles, practice staff)
3. Standing orders
4. Training
5. Involve staff in quality improvements
6. Involve patients in quality improvements

PCMH 3D Use Data for Population Management

1. Outreach for preventive care
2. Outreach for vaccines
3. Outreach for chronic care
4. Outreach for patients not seen recently
5. Outreach for medications monitoring

PCMH 4B Care Planning and Self-Care Support

1. Preferences and functional/lifestyle goals
2. Treatment goals
3. Barriers
4. Self-management plan
5. Care plan provided to patient/caregiver

PCMH 5B Referral Tracking and Follow-Up

1. Tracking to completion
2. Co-management agreements
3. Integrated behavioral health
4. Monitor self referrals
5. Evaluate specialists performance
6. Electronic summary exchange

PCMH 6D Continuous Quality Improvement

1. Analyze, set goals and act to improve
2. 3 clinical quality measures
3. 1 cost/utilization measure
4. 1 patient experience measure
5. 1 disparity for vulnerable patients

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PCMH Domains

- Business operations – Running a practice
- Meaningful Use - Technology
- Care coordination – Medical Neighborhood
- Care management – Treating and engaging patients
- Quality improvement – Measuring everything
- Financials – Getting paid

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PCMH Elements by Domain

Points	Standard/Element
10	**PMCH 1: Patient-Centered Access**
4.5	Element A Patient-Centered Appointment Access
3.5	Element B 24/7 Access to Clinical Advice
2	Element C Electronic Access
12	**PMCH 2: Team-Based Care**
3	Element A Continuity
2.5	Element B Medical Home Responsibilities
2.5	Element C Culturally and Linguistically Appropriate Services
4	Element D The Practice Team
20	**PCMH 3: Population Health Management**
3	Element A Patient Information
4	Element B Clinical Data
4	Element C Comprehensive Health Assessment
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Points	Standard/Element
20	**PCMH 4: Care Management and Support**
4	Element A Identify Patients for Care Management
4	Element B Care Planning and Self-Care Support
4	Element C Medication Management
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5	Element E Support Self-Care and Shared Decision Making
18	**PCMH 5: Care Coordination and Care Transitions**
6	Element A Test Tracking and Follow-Up
6	Element B Referral Tracking and Follow-Up
6	Element C Coordinate Care Transitions
20	**PMCH 6: Performance Measurement and Quality Improvement**
3	Element A Measure Clinical Quality Performance
3	Element B Measure Resource Use and Care Coordination
4	Element C Measure Patient/Family Experience
4	Element D Implement Continuous Quality Improvement
3	Element E Demonstrate Continuous Quality Improvement
3	Element F Report Performance
0	Element G Use Certified EHR Technology

Classification is based on the plurality of Factors for each Element

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PCMH – A Practice Management Framework

An opportunity….

What are your practice goals?

PCMH

- Financial Management
- Operations Management
- Care Management
- Quality Management

Missing from NCQA PCMH

Included in NCQA PCMH

Step1:
Define *your* goals

Step 2:
Refine & expand the framework to address *your* goals

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Frequently Asked Questions

- **Is this just more bureaucracy and paperwork?**

It shouldn't be. This is about patient care and positioning your practice for better reimbursement and sustainability.

- **Is it going to be hard?**

It depends on how you practice today. Either way, we'll be there to help you out.

- **Is it going to cost a lot of money?**

It doesn't have to. You don't need to hire people, and even an EMR is not absolutely necessary.

- **Can I try it out before I commit?**

Yes, you can. You can use tools to walk you through the framework, get an idea on what is involved and try it out one step at a time.

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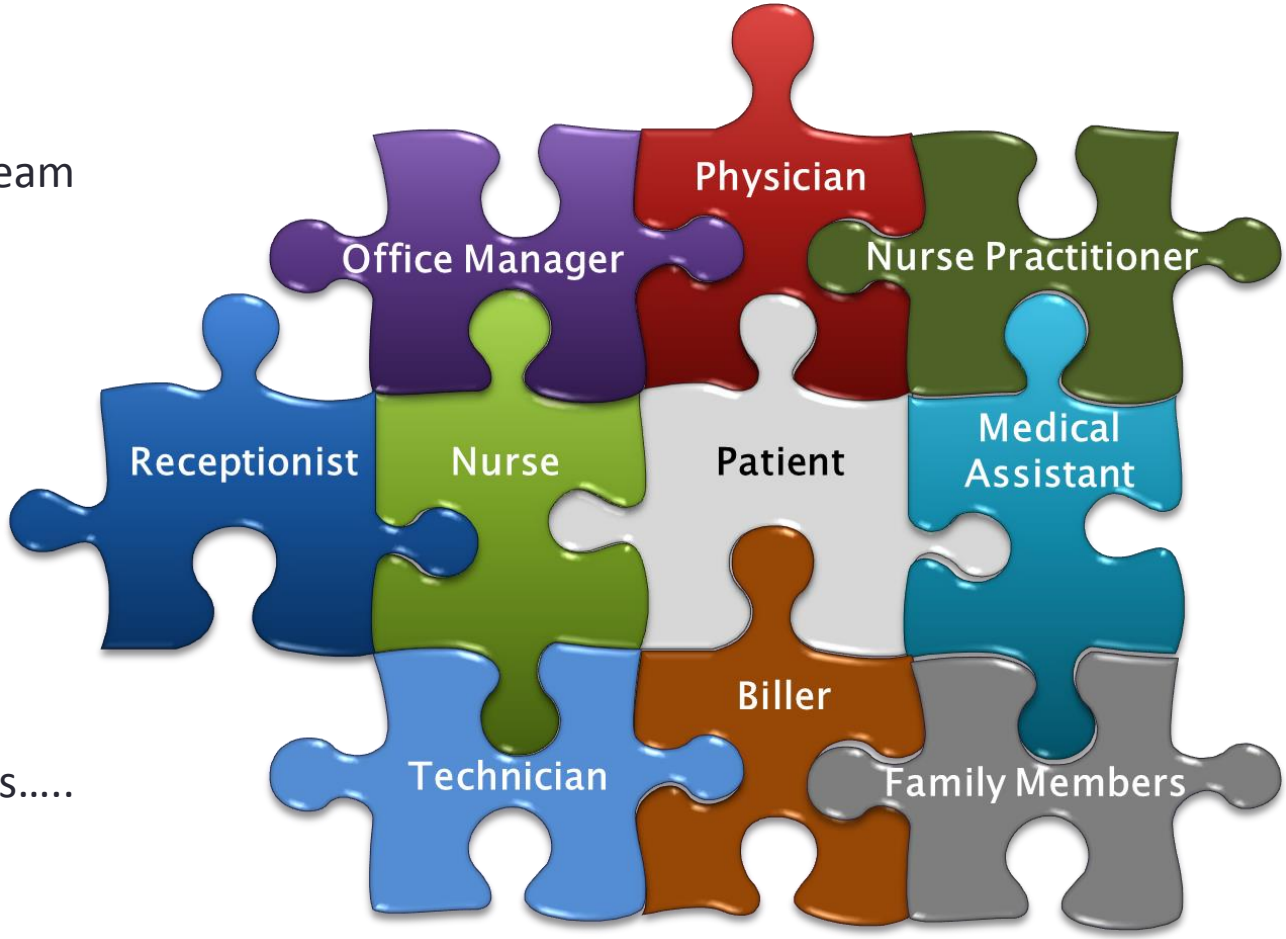
Getting Started with Your PCMH

The foundation of a PCMH – The Medical Home Team

Every practice is a team



Even solo practices…..

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PCMH Roles and Responsibilities

Clinical Responsibilities	Coordination Responsibilities	Administrative Responsibilities
Instituting care guidelines	Tracking transitions of care	Instituting policies and procedures
Instituting standing orders protocols	Population analysis and stratification	Tracking patient communications
Implementing checklists	Outreach to patients	Running reports
Setting quality improvement goals	Patient education	Administering patient surveys
	Pre-visit preparations	Chart Review
		NCQA recognition process

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PCMH Outcomes: Smarter Healthcare

- Drop in hospital days - 36.3%*
- Drop in ER use - 32.2%*
- Reduction in total costs - 9.6%*
- Reduction in outpatient specialty care - 15.Q%*
- Improvements in chronic disease and preventive care*
- Decreased staff burnout§
- Higher patient experience ratings§

* Outcomes of Implementing Patient Centered Medical Home Interventions: A Review of the Evidence from Prospective Evaluation Studies in the US, K. Grumbach & P. Grundy, November 16th 2010

§ Patient-centered medical home demonstration: a prospective, quasi-experimental, before and after evaluation. Reid RJ, Fishman PA,Yu O, Ross TR, Tufano JT, Soman MP, Larson EB. Am J Man Care, 2009 Sep 1;15(9):e71-87

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Why PCMH?

- **Quality Chasm**
- **Healthcare costs**
- **Declining physician and staff satisfaction**
- **Patient dissatisfaction**
- **Health information technology**
- **Performance measurement & reporting**
- **Changes in payment methodologies**

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Improvement Team

- **Form a team**
  - **3-6 members (2-3 if small clinic)**
  - **Roles:**
    - **Provider champion**
    - **Day-to-Day leader**
    - **System leader**
    - **IT leader**
    - **Other (Front Desk Staff)**
  - **Meet 2x per month to get started – regular meetings**
  - **Review PCMH materials and develop game plan**
  - **Accountable for deliverables**
  - **Practice transformation and medical home development CANNOT be done by one person**

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Practice Assessment

- **Assess your practice**
  - **Practice profile**
    - **Lists strengths and challenges**
    - **Identify opportunities for improvement**
    - **Increase your understanding of your patients - # of patients with selected chronic disease; average wait time for your patients…**
  - **PCMH Assessment**
    - **Complete PCMH Assessment tool - http://www.safetynetmedicalhome.org/sites/default/files/PCMH-A_0.pdf**
    - **Tool will identify strengths and gaps**
    - **Use PCMH Assessment to set priorities and develop game plan**

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Why Now?

- **Rural Health Clinics increasingly are expected to measure, report and improve quality measures and demonstrate clinical and operational improvements**
- **Alignment with**
  - **Meaningful Use**
  - **Performance reporting**
  - **EHR Implementation & Support**
  - **Workforce Management**

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QUESTIONS???

Thank you!
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